SPRING NUMBER, 1918.

Vol. XXXVI. *No.* 135.

JUN 17 1918
UNIV.

THE BRISTOL MEDICO-CHIRURGICAL JOURNAL

PUBLISHED UNDER THE AUSPICES OF

THE BRISTOL MEDICO-CHIRURGICAL SOCIETY.

Editor: P. WATSON-WILLIAMS, M.D.,

WITH WHOM ARE ASSOCIATED

J. LACY FIRTH, M.S., M.D., JAMES SWAIN, C.B., M.S., M.D.

J. A. NIXON, B.A., M.D., *Assistant Editor.*

Acting Editorial Secretary: W. A. SMITH, M.A., M.B.

CONTENTS.

	Page
Some Developments in Abdominal Surgery. By F. LACE, F.R.C.S.	1
Editorial Notes	18
Obituary Notices:	
JOHN MICHELL CLARKE	23
HAROLD F. MOLE	31

BRISTOL: J. W. ARROWSMITH LTD.

LONDON: SIMPKIN, MARSHALL, HAMILTON, KENT & CO. LTD.

Price One Shilling and Sixpence net.

PEPTENZYME.

The Nucleo-Enzymes of the Salivary, Peptic, Pancreatic, Spleen, and Intestinal Glands.

Employed in Gastric Catarrh, Atonic Dyspepsia, and Constipation.

Assists the Digestive organs to resume their functions by starting normal active digestive secretion, which may require only a slight impulse by proper stimulation of the surfaces and orifices of the gland cells and of the ducts leading to the digestive canal.

Bottles of 50 and 110 Tablets. Powder, 1¼ ozs. Elixir, 8 and 16 ozs.

Distributing Agents:

Anglo-American Pharmaceutical Company Ltd.,

Telephone: 1718 Croydon (Nat.)

CROYDON, LONDON.

"PANCROBILIN" (Reed & Carnrick).

(NUCLEO-ENZYMES OF THE PANCREAS WITH DEHYDRATED BILE.)

Increases the flow of Bile and activity of Liver, preventing the formation of Gall-stones.

Many cases of Constipation grow worse under the continued use of cathartics and purges. The normal stimulant to the intestines is found in the pancreatic juice and the bile. Pancrobilin is composed of the nucleo-enzymes of the pancreas with dehydrated bile. The nucleo-enzymes of the pancreas are more active and truer to Nature's secretion than pancreatin. So dehydrated bile is better than the ordinary bile salts, because the water has been removed without the use of high heat, which changes the nature of the bile as it normally exists; consequently Pancrobilin is more effective than the usual combinations of pancreatin and desiccated bile.

Original bottles of 100 gelatine-coated small pills for dispensing.

FREE SAMPLE TO PROFESSION.

ANGLO-AMERICAN PHARMACEUTICAL CO. LTD., Galen Works, Dingwall Road, CROYDON.

J. Mitchell Clarke.

The Bristol Medico-Chirurgical Journal.

"Scire est nescire, nisi id me
Scire alius sciret."

SPRING NUMBER, 1918.

SOME DEVELOPMENTS IN ABDOMINAL SURGERY.

The Presidential Address, delivered on 12th December, 1917, at the opening of the Forty-fourth Session of the Bristol Medico-Chirurgical Society.

BY

F. LACE, F.R.C.S.,

Honorary Surgeon, Royal United Hospital, Bath.

IN taking the Presidential Chair of this Society, I feel that I must again express my very great appreciation of the honour you have done me in electing me to this position, and all the more so in that I think this is only the second occasion upon which a member of the Society non-resident in Bristol or Clifton has been nominated as President. I shall always consider it the greatest compliment which my professional friends in this city could have paid me.

When I think of the distinguished men, many of whom were my teachers thirty years ago, who have occupied this chair, it seems almost presumptuous to attempt to follow in their footsteps. However, I will do my best, and being fairly

well conversant with the affairs of the Society, hope that I may carry out my duties to your satisfaction.

The foremost and most difficult of those duties is that of addressing you on this occasion. Two great difficulties beset me. In the first place, in these times of stress it is more than difficult to get through one's daily work, much more to find sufficient time to give adequate thought to the subject of an address to a scientific society. In the second place, the fact of not being connected with a School of Medicine, as practically all my predecessors have been, is a real handicap. One misses the incentive to take a comprehensive and detailed grasp of the subject in view, and the facility of language which must come to anyone daily occupied in imparting the knowledge which he has acquired.

I could have wished to address you on what I may call some by-path in our profession, such as that of the surgical superstitions which are still handed down to the student in our text-books. But time has not sufficed. Many other subjects have passed through my mind, but been abandoned for the same reason, and eventually my thoughts carried me back to my student days at the Royal Infirmary, and to one of my teachers whose name will always take a foremost place in the annals of this Society. I refer to Mr. Greig Smith. I was his dresser for an unusually long period, and it was impossible to be associated with him without being affected by his unvarying kindness, high ideals—as shown in his Presidential address to this Society—and enthusiasm in his work. To him must be ascribed my interest in the subject of Abdominal Surgery, and it is not too much to say that any success I may have achieved in practice is directly due to him more than to anyone else.

It was at this time, just thirty years ago, that he published the first edition of his *Abdominal Surgery*, a book which, as has been said, " filled a void much felt at the time of its first

publication, and was welcomed in the warmest terms, not only in this country and America, but also on the continent." Upon taking down my copy and glancing through its pages once more, it occurred to me that it might not be amiss, after this lapse of time, to spend the few moments at my disposal this evening in considering some of the advances which have been made in this branch of surgery since this book was published.

The subject of Abdominal Surgery has, of course, become too vast to allow of any detailed review, but it may be useful to point out the general principles upon which such advances have been founded, and which in many instances do not seem likely to be improved upon.

And here may I recall the warning uttered by Greig Smith in his preface. He says: "From a practical point of view, it is expedient that the surgeon, who makes an abdominal section for a preconceived purpose, should be ready off-hand to deal with an unexpected contingency. The recondite nature of many abdominal diseases frequently necessitates conclusions to operative procedures very different from what were contemplated. Confidence and capacity on the part of the surgeon who ventures upon abdominal work can scarcely exist apart from a complete knowledge of all abdominal operations." I fancy that this warning is just as necessary nowadays, if not more so, as then. It is difficult enough for those who are almost daily opening the abdomen, to keep abreast of the many advances which are being constantly made in technique, etc., and yet many others are bold enough to undertake such work with the scantiest knowledge of the difficulties which they may have to face. How complicated even an operation for appendicitis may prove to be!

As in connection with all other branches of surgery one particular advance has taken place, the substitution of aseptic for antiseptic methods. In my student days the

use of the carbolic spray was universal. All instruments, towels, sponges, and hands were soaked in the same fluid, much to the detriment of one's skin, and one left the operating theatre saturated inside and out with the antiseptic. How much simpler and more secure is sterilisation by steam and boiling, and how much irritation of the tissues, both of the patient and operator, is avoided. I mentioned sponges just now. Swabs and pads of various sizes and material have taken the place of marine sponges, but I sometimes wonder whether we were wise in abolishing the large, flat sponges, quite easily sterilised, as Lister pointed out. Has anything been devised quite so efficient for the purpose for which it was used, the " packing-off " of the site of an operation in the abdomen ?

As regards diagnostic methods, there is little to add to the very complete chapters on the subject in the work which serves as my text-book. The discovery of the X-rays had not then been made. To-day we could not well do without this method of examination in conjunction with the bismuth meal. The diagnosis of pathological conditions of the stomach by these means has been materially improved, particularly in America ; and how useful it is to be able to sort out cases of real mechanical obstruction of the bowels from amongst the myriads of people suffering from that popular condition styled " intestinal stasis." How many less exploratory operations for renal calculus are now performed, since the presence of a stone in any part of the urinary tract can be almost certainly demonstrated to us on a photographic plate.

Speaking of the kidney reminds me of another means of diagnosis not in use in those days, but which has now for a long time become a routine practice. I refer to the cystoscope, with or without the ureteral catheter. This instrument now enables us to diagnose with precision conditions formerly

characterised by a considerable degree of doubt, and in some instances to apply local treatment.

I will now consider some of the more common abdominal operations seriatim, and will commence with :—

Ovariotomy.—This may be looked upon as the pioneer operation of abdominal surgery. By the time Greig Smith's book was written the operation had reached a stage of finality which has not been improved upon since. The extra-peritoneal treatment of the pedicle by use of a clamp had been abolished, as had also the treatment by clamp and cautery, vicissitudes through which other procedures have passed, and the simple intra-peritoneal method of ligature had been generally adopted. All the difficulties and complications which might arise in the course of the operation were well recognised and described, and the practice of the operation remains to-day where it was then.

But when we come to the consideration of the removal of the uterine appendages there is more to be said. I do not refer to the removal of the ovaries and Fallopian tubes for inflammatory conditions, but to oöphorectomy performed for the purpose of producing an artificial menopause, for functional neuroses, hystero-epilepsy, menorrhagia, or for the cure of uterine fibro-myoma. Greig Smith fully discussed the arguments for and against Batty's operation, as it was called, and considered it of value in certain conditions, even going so far as to say that in the treatment of hystero-epilepsy the results were promising, and we used to see very many more ovaries removed in those days than now. I believe and hope that oöphorectomy for such conditions is rarely adopted nowadays. In fact, the wholesale removal of ovaries seemed at one time to be a source of discredit to the profession.

The removal of the appendages, with a view to preventing the growth and causing the atrophy of uterine myomata, falls

under a different category, and appeared in those days to be likely to be generally adopted, and it was foretold that it would in the future mean fewer hysterectomies. This prophecy, however, has not held good, and I suppose the operation is now never performed for this purpose, mainly because we soon learnt that such tumours do not of necessity undergo atrophy after the menopause, to say nothing of the dangerous degenerative changes which not infrequently occur in them.

Operations upon the Uterus.—In the first place I take *Hysterectomy*, which in 1887 was rarely performed for any condition other than malignant disease or fibro-myoma. For malignant disease the operation was performed by the vaginal route. Greig Smith said that the abdominal operation was "almost universally discarded," and that with a proper selection of cases "recurrence is almost certainly not more rapid than in other operations for cancer, and permanent recovery is just as likely to be secured." In many cases partial operations were performed, and when the disease appeared to be confined to the cervix, it was considered that amputation of this portion alone was called for.

I have never performed the operation of vaginal hysterectomy, for the results of the cases which I saw in my early days were not encouraging; but there is no doubt that it was a very satisfactory operation in good hands, and the mortality in those days was decidedly lower than in the high operation. As time went on we realised that, as in other regions, the whole secret of success in the removal of malignant disease lay in the wide excision of all possibly infected tissues, particularly of lymphatic vessels and glands, and this could not be satisfactorily accomplished in the case of the uterus per vaginam. And so we came to adopt the operation by the abdominal route, now spoken of as the Wertheim operation. By this technique we are enabled to remove the

parametric tissues as widely as possible, and also the lymphatic glands in the pelvis and iliac regions, or higher if necessary. The risk of wounding the bladder and ureters, so frequent an accident in vaginal hysterectomy, is thus minimised—though apparently it does still occur—and it is possible to resect them if necessary. The scope of the operation has also been widened, many a case which appears too far advanced for removal from below proving amenable to operation from above. Unfortunately the proportion of cases that we come across that are not too advanced for removal is still very small, and one almost despairs of any improvement in this respect.

All the hysterectomies for fibro-myoma that I saw in those days—and they were few in number—were performed by the use of Koeberle's wire clamp, with extra-peritoneal treatment of the stump. The broad ligaments were usually included in the stump, but Greig Smith recommended that they should be ligatured and divided in some difficult cases in order to obtain a more satisfactory pedicle. Intra-peritoneal treatment of the pedicle did not give satisfactory results, the mortality being given as 56.2 per cent., as against 33.3 per cent. with the extra-peritoneal method. Greig Smith did, however, write that "no doubt the advancing surgery of the day will not rest until some intra-peritoneal method has been devised which will excel all others." Such a method was somewhat slow in evolution, and it has always seemed surprising to me that we did not earlier take to deliberate ligature of the broad ligaments and uterine arteries, whereby the total or sub-total removal of a fibro-myomatous uterus has become in many cases an almost bloodless operation, and the mortality has been reduced to insignificant proportions. As in so many other operations, the advance has been entirely towards simplicity of technique.

Of *Cæsarean Section* I will say but a few words. The

operation as described thirty years ago is that of to-day. The results are better owing to the fuller recognition of the fact that early operation is the chief factor making for success. The operation is much more frequently performed. Indeed it is a question whether it is not being to some extent abused. Taking cases at all stages of labour, the mortality is still by no means negligible, and what is a comparatively easy operation should not serve as an excuse for obstetrical ignorance.

There is a class of operations on the uterus, not practised in my early days, which deserves mention, namely the various procedures which have been adopted for the treatment of displacements, more particularly procidentia. The varieties of method recommended are innumerable, ranging from a simple ventro-fixation, or plication of the round ligaments, to splitting of the organ and incorporation of the segments in the abdominal wall, and their very number only goes to prove that none is of anything like universal benefit. Nevertheless, I have long been of opinion that it were better if practitioners would advise their patients to undergo some simple surgical treatment in the early stages of this condition, rather than to condemn them to the prolonged use of that objectionable instrument, the pessary.

Operations on the Stomach.—Gastrostomy was a well-recognised procedure. Greig Smith considered that the operation was "systematically delayed too long," a fault much less applicable nowadays. But he was "of opinion that considerable weight ought to be given to the desires of the patient after an honest and impartial statement of the possible and probable results have been put before him. My experience is that he elects not to be operated upon." The operation which he elaborated and described was excellent in those days, when the chief aim was to obtain firm adhesion of the stomach to the abdominal wall before opening it.

The improvement in technique which soon followed consisted in the addition of a channel through which the tube is passed, such channel being provided by infolding the stomach walls by one or other of several methods. Thus the tube can be introduced at once, food immediately given, and leaking prevented. Such is the operation of to-day, and one feels far more justified in recommending it, the immediate result and prognosis being so much improved, especially if not too long delayed. It is surely worth while to be spared death from starvation.

Operation for *Perforating Gastric Ulcer*, although described, I never saw whilst at the Royal Infirmary, and I believe it was some years later when it came into general use. Presumably this was because the condition was not diagnosed in a sufficiently early stage, as no doubt perforation of these ulcers was as frequent then as now. Nowadays there is seldom any difficulty in the diagnosis, and a large proportion of the cases are saved, either by simple suture, or suture in conjunction with gastro-enterostomy. Whether or not the abdomen should be washed out in these cases is still a vexed question. I have recently read an account of a series of cases in which lavage was not once used, and in which it is condemned ; but in all my cases—a considerable number—I have invariably practised copious irrigation, and have had no reason to regret it.

For *Pyloric Obstruction* dilatation or pyloroplasty were the operations usually performed. Anterior gastro-enterostomy was described as a method of treatment, but had seldom been employed. The posterior operation had not then been practised, and even ten years later Greig Smith wrote that the results were such that the operation had been abandoned, kinking of the jejunum at the site of anastomosis being the objection. This method, however, was soon after generally adopted, and the danger of kinking avoided by

making the point of junction as near the commencement of the jejunum as possible, instead of at a point about a foot lower down, as was at first recommended. I must confess that I never could understand why the method of leaving a loop was ever adopted, except perhaps that it made the necessary manipulations easier, and after my first operation I abandoned it for the more common-sense no-loop method, though I had not seen it described. In these days there is a considerable variety of operations in use for the purpose of producing an anastomosis between the stomach and duodenum or jejunum, which I need not go into. They are all useful under the varying circumstances which may be met.

There has been much difference of opinion as to whether this short-circuiting operation should be recommended in cases of malignant disease of the stomach. My experience is that if taken in time it usually gives the greatest relief, prolonging life sometimes for upwards of a year, and at any rate preventing death from starvation.

Pylorectomy or partial *Gastrectomy* had seldom been performed, and had given very fatal results. Gradually the technique of these operations has improved, so that the operative mortality has been reduced to reasonable proportions. Also by an accurate knowledge of the lymphatic system of the stomach we have learnt how much of the organ and which of the neighbouring lymphatic glands should be removed, in order to reduce the chances of recurrence of the disease as far as possible. Probably the most recent method of completing a gastrectomy by uniting a long loop of the small intestine directly to the divided stomach will prove to be a decided advance, the length of the operation being thereby considerably shortened.

Before leaving the subject of operations upon the stomach, may I express the opinion that the greatest desideratum always has been, and still is, some means of early and

accurate diagnosis of the conditions, which can only be effectively treated surgically if recognised in an early stage. The greatest advance appears to me to have been made by the use of the bismuth meal and X-ray examination, and I have been particularly struck by the painstaking and excellent result which has been accomplished by these means in the United States.

Next I come to the subject of operations for the relief of *Intestinal Obstruction.* Greig Smith gave us in his work much and most excellent advice on this subject, advice which has been reiterated by every writer since. In those early days practically no cases were handed over to the surgeon until treatment by drugs had been prolonged to the utmost limit, and it was necessary to state, as he did, that "if we are doubtful whether we can do good by operating, we may be certain that there are many ways of doing harm by administering drugs." These criticisms have had their effect, and large though the mortality still is from acute intestinal obstruction, it cannot be now said that there is much undue delay in seeking surgical interference.

As regards operative details, it was then, probably for the first time, urged that "no operation for intestinal obstruction is properly completed if the patient leaves the table with a greatly distended abdomen, evacuation of the contents being an essential proceeding." With this end in view, Greig Smith advised a temporary enterostomy in cases in too serious a condition to admit of any prolonged operation. I wonder how many lives have been saved by this simple procedure.

Short-circuiting by means of a lateral or other form of anastomosis, as a temporary or permanent measure of relief for obstruction, was a later development, and, as you are aware, is now frequently practised.

In the treatment of Intussusception we do not now waste

valuable time in efforts at reduction by insufflation, but open the abdomen and reduce it manually, thus greatly reducing the mortality.

Another operation which I do not recollect seeing when a dresser was *Resection of the Intestine.* A good many cases had been recorded, and it was then regarded as one of the most successful of heroic operations. The mortality was mainly due to peritonitis resulting from some defect in the operation, and no doubt the better results of the present day are largely due to improved methods of preventing contamination of the peritoneal cavity, *i.e.* the careful " packing-off " of the operation area. Although there is still a large variety of modes of suture described, probably in practice but few are in general use. Nor is there any call for any but the simplest methods, such as will fulfil two or three essential requirements. Generally speaking, continuous sutures have taken the place of interrupted, and taking the usual plan of two layers of suture, the inner one should aim at inverting the cut edges of the gut and bringing the serous surfaces into apposition, at the same time controlling hemorrhage; whilst the outer should be such as, when tightened, is as far as possible buried, so minimising the risk of subsequent adhesions to neighbouring parts.

During the present war, when multiple wounds of the intestine have to be dealt with as rapidly as possible, it has been proved that a single line of suture penetrating the whole wall of the bowel is usually quite efficient. Mechanical aids, in the shape of cylinders and bobbins, have been discarded, the only exception being in a low resection of the rectum, where a large rubber tube, fixed into the proximal segment, is of the greatest assistance in invaginating the cut edges and allowing of efficient suturing in a difficult position.

The prognosis as regards recurrence after resection of malignant growths of the intestines has been much improved,

in the same way as in connection with gastrectomy, namely by a thorough study of the lymphatic areas of the different portions of the bowel, and consequent wider removal. There seems to be no limit as to the amount of bowel which can be removed with impunity as far as nutrition is concerned. We are led to believe that the large intestine is of no use to us, if not a positive danger, and that we should live longer without it; and I can personally vouch for the fact that satisfactory nutrition can be obtained when all but about eighteen inches of the small intestine has been put out of action.

The question of operating for localised or general peritonitis is much too extensive to be dealt with now, but I may mention that I never saw the appendix vermiformis removed whilst I was at the Royal Infirmary, although it was well recognised as a cause of suppurative peritonitis. One can hardly realise the change which has taken place in practice in connection with this small portion of our anatomy, and I cannot help wondering whether the pendulum has not swung too far in the other direction. Every discomfort in the right side of the abdomen seems to be traced to the appendix, and the public have heard so much about appendicitis, and have such a dread of it, that upon the least provocation they demand its removal. None of us will deny that early operation and removal of the organ have saved very many lives; but must we not at the same time admit that very many unnecessary appendicectomies are performed when the organ is said to be "quiescent," but in reality has nothing the matter with it, and never had.

The best method of performing *Colotomy*—or *Colostomy*, as I think it should be called—had not, at the time of which I am speaking, been settled. The lumbar or extra-peritoneal route had for a long time been in general favour, and even then was usually chosen, the mortality being said to be less than that of the inguinal operation. But the anterior or

trans-peritoneal method was being steadily revived, and not many years later was generally adopted, though the procedure was somewhat modified. In the older operation a portion only of the circumference of the gut was sutured to the parietes, but when it was revived it was found better to pull out an entire loop of bowel and to fix it in position by acupuncture needles, or by a glass rod or other instrument passed beneath it. Later it was proved that one or more sutures passing through the parietes on either side and beneath the bowel was quite sufficient to keep it in position, and this procedure has not been improved upon?

Operations upon the *Gall-bladder* and *Bile Ducts* were few in number, and I believe that I acted as "dresser" to the first case of the kind upon which Greig Smith operated, a case of a single gall-stone impacted in the cystic duct. Of course most of these operations are performed for the removal of biliary calculi, and as we came to recognise more fully the baneful effects of temporary or permanent biliary obstruction, so the number of operations increased. The modes of attacking calculi in the various parts of the ducts have been elaborated, and, notwithstanding the extreme difficulties often met with, the results are wonderfully good. Apart from obstruction to the flow of bile into the digestive tract, we know that there is great danger from septic absorption in these cases, and therefore it is almost universally considered that drainage of the gall-bladder or ducts is an essential finish to all such operations. That it is not essential to drain the common duct after the removal of a stone from its lumen I know, for I have always closed the incision in the duct without drainage, and without any ill-effects to my knowledge. As regards the gall-bladder it is different, for it is so frequently at least chronically inflamed, and hence is the source of the septic absorption that we fear.

If the gall-bladder appears to be in a normal condition, I

am one of those who see no objection to immediate closure, so that I have often performed what is styled the "ideal" cholecystotomy, widely though it is even now condemned. Again, it appears to me that when the viscus is evidently diseased it is a sound procedure to excise it, notwithstanding the loss of drainage facilities, for the septic focus is in this way removed, and the necessity for drainage avoided. Cholecystectomy is, therefore, more widely practised than formerly, and I find that I more often than not complete operations for gall-stones in this way. The fact that malignant disease of the gall-bladder is almost always due to chronic irritation by gall-stones is another strong argument in favour of its removal, when it is evidently in a state of long-standing inflammation. The argument that its removal would make any subsequent operation upon the bile-passages more difficult and severe should not be given too much weight, for the necessity for such, though possible, is highly improbable.

Before leaving the region of the liver, let me refer to the surgical treatment of *Cirrhosis* of that organ, producing ascites. This has gradually become an established procedure. The operative mortality was at first high, but has been largely reduced by the proper selection of cases. As you know, the desired result has been obtained by promoting adhesions between the liver and the diaphragm, or of the omentum to the abdominal parietes, or by drainage of the peritoneal cavity into the subcutaneous tissues. Opinions differ as to whether the improvement is due to the relief of the portal circulation by provision of a collateral venous flow, or by the improvement of the blood supply of the liver. Anyhow, it is an operation which might well be more often undertaken.

Operations upon the *Kidney*, *Ureter* and *Bladder* are not always considered to belong to the domain of abdominal

surgery, although it is not quite clear why. It is true that they are generally conducted extra-peritoneally, but by no means always so. As stated earlier, the main improvement in the surgery of these organs consists in methods of diagnosis, due to the routine use of the cystoscope and ureteral catheter. There is little excuse now for attacking them without knowing definitely what the condition is with which we have to deal. I think Greig Smith must be acknowledged to have taken a foremost place in resuscitating suprapubic cystotomy, if only for the removal of calculi. It was not long, however, before it was adopted for the removal of innocent and malignant growths, as well for the enucleation of the hypertrophied prostate gland. As regards prostatectomy, I am tempted to express the opinion that the ultimate result of this operation is not by any means always so satisfactory as is generally represented. It is those of us who have prolonged care of our own cases, or the after-treatment of patients leaving the hands of others a few weeks after the operation, who realise the troubles which may occur owing to delay in healing of the wound in the base of the bladder, and the cicatricial contraction of its neck.

There are two other organs to which a short allusion should be made, the *Pancreas* and the *Spleen*. In regard to the former, it is cheering to find records of an increasing number of successful operations for Acute Pancreatitis by means of incisions and drainage. And as regards Splenectomy, although it was performed some few times many years ago, in a casual way, for "simple hypertrophy," yet it is only during the last few years that it has come to be adopted as a recognised method of treating Splenic Anæmia and other blood conditions. In such conditions it seems to promise at least relief from symptoms and prolongation of life in a fair proportion of cases, and is not unlikely to become more generally adopted.

Here I will bring to a close this very superficial and somewhat scrappy survey of some of the developments in Abdominal Surgery which I have witnessed. I have found it interesting to " think back " for a while, and to realise that the advances in surgery during our time have been very real ; that many procedures of thirty years ago have not been improved upon ; that many others, then only tentatively undertaken, have been generally adopted ; whilst still others, then hardly dreamed of, have been permanently added to our resources.

Editorial Notes.

The Late Lieut.-Colonel Prof. Michell Clarke, Associate Editor.

By the death of Colonel Michell Clarke this *Journal* has lost one of its most valued contributors: the Editor mourns the loss of the senior member of his Editorial Staff. To a man of so many parts, whose reputation as a Consulting Physician was second to none in the West of England in his day and generation, his immense work for the *Journal*, continued over so many years, was relatively one of his minor interests. Yet it is significantly characteristic of Michell Clarke that his work for us was always carried out with punctilious care, his advice was ever sound, his guidance always to be trusted. In our obituary notice fuller justice is paid to the personal life and character and to the work of our friend and colleague; here we desire rather to express the feeling of irreparable loss to our readers of which the Editor is profoundly sensible. The first and dominant thought on hearing that Michell Clarke had passed from us was the untimeliness of death in the zenith of professional success and full vigour of life and faculty, the sense of work unfinished. Yet one glance at the bibliography of his contributions to Medicine serves to remind one what Clarke had accomplished, and that for such men the full harvest is never gathered. We understand that steps are being taken to perpetuate the memory of this great man, and we may feel assured that the Memorial will be worthy of the occasion; but we also trust that this

opportunity will be used not merely to remind future generations of what Clarke was and did, but to carry on and develop his own contributions to Medical Science which he loved and served so well.

* * * * *

Colonel J. A. Nixon.

WARM congratulations to Colonel Nixon, A.M.S., appointed Consulting Physician to the Fourth Army in France.

* * * * *

The case of Dr. John Henderson Bell.

THE attention of all practitioners of medicine should be directed to the case of Dr. J. H. Bell, of Chelsea, who after practising for seventeen years, and by his upright life and professional skill had secured the confidence of a large number of patients, has been "convicted" apparently for an "act preparatory to an act" to enable a soldier to evade military service. A fairly complete account of the case has been reprinted, and has been sent to us by the Rev. Dr. Pentreath, Adderley Rectory, Market Drayton, Salop, and copies can be obtained by forwarding to him a stamped and addressed envelope. We urge all our readers to apply for a copy. The *Lancet* of March 2nd, in commenting on the case, states that "the manner in which the evidence was procured against him does not appear to us creditable to our times, and the quality of that evidence leaves the benefit of grave doubt on Dr. Bell's side. We cannot withhold from ourselves the conviction that we have here a case of miscarriage of justice." Briefly the accusation was that when called to see an Australian soldier (Orr), who he found with his leg resting on a table complaining of great pain, having as the soldier stated

fallen off a bus the previous night, the doctor injected something in the knee to render the soldier unfit for military service. The examination seemed to cause great pain, so Dr. Bell said he gave an injection of morphine only, advising the patient to take a cab and go to a hospital. This was in January, 1917. In May, 1917, a trap was laid, Dr. Bell being called to see a "patient" complaining of nasal trouble. He proceeded to examine the man's nose, and painted the mucous membrane with supra-renal extract to get a better view of the nasal passages. Thereupon three persons concealed rushed into the room and arrested the doctor, the "patient" being Hawkins, a disguised warrant officer. Apparently it was assumed that the doctor was about to do something to the nose to render the "patient" unfit for service. But as it was admitted that the doctor had no instruments which would have any such effect, it is difficult to understand how such assumptions could support the case. Several well-known surgeons and nasal specialists have considered the evidence, and certify as follows :—

Medical Statements.

We certify that we have individually considered the evidence in the case of Dr. John Henderson Bell.

We are emphatically of opinion :—

(1) That Dr. Bell's examination of Orr was proper, and his advice that he should go to a Military Hospital correct.

(2) That, in view of the presence of swelling of the knee and the man's complaint of great pain, the injection of a quarter of a grain of morphia was justifiable.

(3) That, as the leg was exposed, there was nothing unusual in the injection being made into the thigh.

(4) That if any fluid capable of causing incapacity for Military Service had been injected into the knee-joint,

the man would not have been able to walk about as he did during the subsequent three days before going to hospital.

(Sgd.) WILLIAM HY. BATTLE, F.R.C.S.,
Senior Surgeon St. Thomas' Hospital, &c.

(Sgd.) WALTER G. SPENCER, F.R.C.S.,
Senior Surgeon Westminster Hospital, &c.

(Sgd.) EDRID M. CORNER, F.R.C.S.
Surgeon to St. Thomas' Hospital, the King George Hospital, the 5th London General Hospital, &c.

WE CERTIFY that we have individually considered the evidence in the case of DR. JOHN HENDERSON BELL.

WE are emphatically of opinion :—

(1) That Dr. Bell's examination of the nasal passages in the case of the man Hawkins was in every way usual and proper.

(2) That with the instruments Dr. Bell had with him it would have been impossible for him to have done anything injurious to the nasal passages.

(3) That nothing in Dr. Bell's examination could possibly be regarded as preliminary to, or leading up to, the committing of a criminal act.

(Sgd.) ST. CLAIR THOMSON,
M.D., F.R.C.P. Lond., F.R.C.S. Eng.

(Sgd.) SYDNEY R. SCOTT,
M.S., M.B. Lond., F.R.C.S. Eng.

(Sgd.) FRANK A. ROSE,
M.A., M.B. Cantab., F.R.C.S. England.

The Australian soldier was Orr, who was arrested for desertion while in the hospital to which Dr. Bell referred him, and only then accused Dr. Bell of having injected something into his leg to make him unfit for service. But there was no evidence of such an injection having been made, while as for the " bogus " nose case, everyone who examines the nose of any patient ought to do much the same as Dr. Bell was proved to have done. It has never been shown that Dr. Bell received any monies in connection with the matter beyond one guinea

for his visit to Orr, and which was duly entered in his books.

An appeal to the Home Secretary for re-trial was refused, on the ground that no fresh evidence was adduced, but what possibility is there of such fresh evidence being adduced by Dr. Bell!

If guilty Dr. Bell has prostituted his profession by acts which merit the contempt of his fellows; but—if innocent! the cruelty of such a miscarriage of justice is scarcely measurable. We do not suggest that either magistrates or his judge have been impelled by any but the most honourable of motives, but it is obvious enough to his medical colleagues that the lay mind might be misled by surgical procedures which were innocent and quite usual methods of investigation.

It cannot be doubted that the General Medical Council will go thoroughly and carefully into the whole case, and, *exercising their judicial powers*, deal with it only on its merits. To the Council we look for guidance, either for the protection of society from a scoundrel or the vindication of a martyr, whichever Dr. Bell may be; thus on their judgment hangs an issue of big moment, and for each member a great responsibility.

Further, we protest that to invade the consulting room with a bogus patient, who, in order to make evidence in a trial, is instructed to complain of imaginary symptoms, and then called on to give, as evidence, his layman's views of *what he imagines the doctor intended to do*, places every medical practitioner in a dangerous position, which ought to be illegal, for it certainly is unfair and unbearable.

Obituary.

JOHN MICHELL CLARKE, Lieut.-Col. R.A.M.C.T., M.A., M.D., F.R.C.P., LL.D. Bristol.

The loss of our good friend and colleague, John Michell Clarke, will arouse the deepest regret in our readers, who have so often enjoyed articles from his pen. For over twenty-five years he had taken an active part in the Editorial management and the laborious task of revising and correcting the material for each quarter's issue.

His brilliant scientific achievements, combined with an excellent judgment, and his quiet, modest demeanour, are known to all; but his fellow-workers realise sadly in looking back his remarkable energy and boundless capacity for work. Nothing strikes one more now than the great number of public duties which he carried out efficiently, unless it be the good temper and tact with which he performed them. His whole life was one constant devotion to duty.

It may be interesting to recall that he was the son of a highly esteemed and successful medical man, Mr. W. Michell Clarke, who preceded him on the Staff of the General Hospital, and who was, like his son in later days, President of the Medico-Chirurgical Society and of the Branch of the British Medical Association.

John Michell Clarke was born at Clifton in 1859, and was sent first to a preparatory school (Miss Leedham's), and then to Dr. Hudson's, of Manilla Hall, one of the famous private schools which flourished here at that time. When he was sixteen, he passed into the new and stately buildings of Clifton College, which had recently commenced its prosperous career. Here for three years as a South Town boy he worked his way to the Sixth Form, and left to enter at Gonville and Caius College, Cambridge.

The medical school there had recently been reorganised

under Sir George M. Humphry, one of the most inspiring teachers of the age, who gathered around him such brilliant men as Michael Foster, Gaskell, and Balfour in a determined effort to make that school the most progressive and scientific in England. Clarke soon absorbed the enthusiasm and spirit of his surroundings, but after taking his degree in the Natural Sciences Tripos of 1882 and holding a Demonstratorship of Anatomy he had to leave for clinical study elsewhere.

He dressed for Mr. Nelson Dobson at the Bristol General Hospital, but had the misfortune to get diphtheria in an attempt to revive a drowning man. For a long while he was ill with cardiac complications, but eventually regained vigorous health and went up to St. Thomas's Hospital, where he made the most of his opportunities of studying medicine under such teachers as Ord, Bristowe and Buzzard. He was holding office as House Physician when the sudden death of his father in 1885 and the need of taking his place in Clifton forced him to give up his appointment and the possibility of practice in London.

Settling down in Clifton, he was elected Assistant Physician and Pathologist at the Bristol General Hospital in 1886, and from that time to the day of his death nothing ever lessened the devotion with which he worked for that hospital and his patients there. He was made full Physician in 1893, and for thirty years he took an active share in all the improvements made during that period. In his earlier days he did most of the pathological and museum duties himself, but later on the Committee put up a fine range of buildings and appointed a whole time Pathologist in response to the representations of Clarke and his colleagues. In this as in every other matter his time and careful thought were ungrudgingly given both to the Committee and the Staff, by all of whom his sterling qualities were most warmly appreciated. At this time a movement was going on in the country for the better training of nurses and the improvement of their status. Michell Clarke gave himself warmly to support the efforts of the Hospital Committee, and changes were worked out which revolutionised the education of nurses there, enabling them to

make some provision for the future, and created a highly-trained staff, who were available both for the Hospital and for private cases. He felt keenly that the Hospital should be a school for the best possible education in nursing, and it was largely due to his constant co-operation that the Committee realised many of their ideals. He joined, too, in the work of a Society in Clifton with similar aims, which started and organised the first great Nursing Home with its staff of trained nurses, and is still carrying on a successful work in Chesterfield Place.

At the Bristol General Hospital he found one of his greatest interests in his duties as Dean for the medical students. His inspiring and methodical teaching drew to him a crowd of pupils, to whom he endeared himself by his constant care for their interests as well as by his scientific acumen and powers of exposition.

At the time he began professional life he saw that the opportunities for an advance in Neurology were very great. Hughlings Jackson, Ferrier, Gowers, and some Continental workers had opened up new methods of study. He threw himself with all his vigour into the localisation and pathological anatomy of nerve diseases, studying and utilising every case he met with, and spending his leisure hours in laboratory work. In this field his research and observations produced scientific gains of permanent value, some of which he found time to publish in the sixty neurological papers given with his other writings in the list below; but too many, alas! remain buried in the carefully written note-books he accumulated. His studies on hysteria, on cord degeneration, and on the less known forms of paralyses are of great importance, but his devotion to Neurology did not prevent him from throwing new light on other medical subjects which came before him. Thus we owe to him a careful research on Trench Nephritis, which he saw among the soldiers at Southmead.

The Bristol Medical School, after more or less disorganisation during the eighteenth century, had been definitely revived some sixty years before Michell Clarke began to practise. It had been united to the new University College, but though vigorous it

suffered under great disadvantages. The first of these was the impossibility of giving any degree or registrable qualification. There was also an almost entire absence of any endowments and of whole time teachers. One of the chief teachers complained that the dividend available for his course of lectures only amounted to eighteenpence. Still active teaching was carried on and a good average of successes in the London examinations was maintained. Michell Clarke lectured first in Physiology and then in Pathology, and as usual inspired his students with his own enthusiasm and scientific feeling.

An immense amount had to be done as funds came in to organise the work of the School more thoroughly. In the endless negotiations which followed and were continued when the Charter of the new University was obtained Michell Clarke's solid judgment and his skill in harmonising conflicting interests were of the utmost value. To a remarkable capacity for taking pains he joined a quiet but forcible way of stating his views, which were generally felt to be reasonable and always straightforward and disinterested.

When the University was an accomplished fact he became one of the Professors of Medicine, then Pro-Vice-Chancellor, member of the Council and of the Senate, and for a time Chairman of the Board of the Medical Faculty, all of which made further inroads on his time. His abilities had already been recognised by the Fellowship of the Royal College of Physicians (London) in 1896, and in 1917 he was placed on the Council of that College. Cambridge, too, had recognised his worth by making him an Examiner for the M.B. degree.

On the other hand, he had toiled for ten years for his brethren as Secretary of the Branch of the British Medical Association, with its arduous and often delicate duties. Then to help the Panel practitioners he served for other years on the Local Insurance Committee, when local feeling was running high; and unlike many men with a quarter of his work he gave a steady attendance at the scientific meetings of our Society and those of the British Medical Association, and contributed largely to the discussions.

His addresses as President of both Societies were characterised by their solid value and their happy phraseology. The list below shows the large number of contributions he made to our *Journal*, and he was also an Editor of the *Quarterly Journal of Medicine*, of *Brain*, and the *Journal of Pathology*.

He gave active help, too, in assisting at the foundation of the Winsley Sanatorium, and to the Research Defence Society. As Consulting Physician to the Clifton Dispensary and a Governor of the Victoria Convalescent Home he found other fields of usefulness.

With all this he carried on a large consulting practice, which entailed long journeys over the West of England, as his scientific reputation and character were widely recognised.

When the war broke out he was at once called up as an *à la suite* officer and attached to the Southmead section of the Second Southern Hospital as Senior Physician, with the extra work of the Electrical Department. Summer and winter he covered the three-mile journey by 9 a.m., and before long as Lieut.-Col. he was placed in charge of the administration of the entire section, which was raised to 1,020 beds. This would be a heavy task of itself for one man, since he had besides the soldiers a large number of officers undergoing treatment there, and a numerous staff, among whom he succeeded in maintaining harmonious relations. However, he found time to continue his researches and notes upon his cases, and as one of the Sisters said, "he was never too busy to hear anything we had to say." After many hours at Southmead he had to travel to Bedminster for his patients and lectures at the civil hospital there, and finally to find time and strength for his private patients and literary work.

For over three years this double strain went on. Meanwhile he was called to serve on the Local and on the Central War Committees, with the anxious and trying duty of selecting those doctors who could be best spared for the Front. On the whole, the Committees succeeded in supplying the nation with a huge body of qualified men with the least possible disturbance of medical service for civilians; but it must have

told heavily on a man so kind-hearted and sympathetic towards all his medical brethren.

Chance words at times showed how deeply the fluctuations of the war weighed on his patriotic feelings, but the grievous loss of his second son, who was killed at the Front, was borne with his usual quiet self-restraint.

We have not space to record his successes in golf, which he pursued with his usual thoroughness, rarely satisfying himself with his best performances, nor to describe his enjoyment of the social evenings with the century-old Medical Reading Society, where his huge appetite for new books was sometimes found to be a little embarrassing.

His scientific writings show his powers of observation and his indefatigable labour for the advancement of medicine. but it is to Michell Clarke, the man himself, to whom we wish to pay our tribute here. A man in all things straight, who never stooped to adopt a devious course to obtain his end. To his friends loyal, and to those against whom he might find himself, for the moment, opposed, he was just. Looking back, we can remember no instance where he could be suspected of being unfairly biased by self-interest. A very active and busy man, he was never too busy to help anyone who came to him in a difficulty ; he never spared himself in pains or time to right an injustice. His help was never showy, but it was admirably effective. It was a keen pleasure to him if he could himself slip away from the credit and thanks after matters were righted, but it has been astonishing to learn afterwards from the recipients what tactful and at the same time substantial help he gave to those in adversity.

BIBLIOGRAPHY.

" On Graves's Disease with Case," *Bris. Med.-Chir. J.*, 1887, v. 17.
" Peripheral Neuritis, *Ibid.*, p. 73.
" Notes on Out-patient Cases," *Ibid.*, 1888, vi. 120.
" Progressive Muscular Atrophy with Recovery," *Ibid.*, p. 195.
" B-naphthol in Enteric Fever," *Practitioner*, 1888, xli. 421.
" Three Cases of Friedreich's Disease," *Lancet*, 1889, i. 570.
" A Case of Tetany," *Illustr. M. News*, 1889, iii. 148.
" Treatment of Locomotor Ataxy by Suspension," *Practitioner*, 1889, xliii. 339.

"Clinical Cases," *Bris. Med.-Chir. J.*, 1889, vii. 258.
"Dilatation of the Stomach," *Ibid.*, p. 21.
"Tubercle of Medulla Oblongata," *Ibid.*, p. 194.
"On some Varieties of Paraplegia," *Ibid.*, 1890, viii. 226.
"Case of Syphilitic Growth in Dura Mater," *Lancet*, 1890, i. 460.
"Remarks on Biliary and Hypertrophic Cirrhosis," *Brit. M. J.*, 1890, i. 1000.
(With J. G. Smith) "Case of Removal of Vermiform Appendix with Recurrent Attacks of Inflammation," *Lancet*, 1890, i. 956.
"Hydronaphthol in the Treatment of Enteric Fever and of Diarrhœa," *Practitioner*, 1890, xlv. 1.
"Case of Locomotor Ataxy," *Brain*, 1890, xiii. 363.
"Case of Ataxic Paraplegia with Autopsy," *Ibid.*, pp. 356, 373.
"Some Cases of Hysteria in the Male Subject," *Lancet*, 1890, ii. 1322.
"Value of Suspension in the Treatment of Tabes Dorsalis," *Ibid.*, 1891, ii. 114.
"Case of Tabes Dorsalis," *Brain*, 1891, xiv. 105.
"Case of Total Transverse Lesion in the Upper Dorsal Region of the Cord," *St. Thomas's Hosp. Rep.*, 1891, xix. 23.
"Three Cases of Intracranial Tumour," *Brit. M. J.*, 1891, i. 1283, 1334.
"Three Cases of Hysteria in Man," *Brain*, 1891, xiv. 523.
"Modern Methods of Diagnosis in Gastric Affections," *Bris. Med.-Chir. J.*, 1891, ix. 73.
"On Hysteria," *Brain*, 1892, xv. 522.
"Clinical Observations on Hysteria," *Lancet*, 1893, i. 1123, 1185.
"Multiple Abscess of the Liver," *Practitioner*, 1893, li. 270.
"Case of Intracranial Hydatid Tumour with Hemiplegia," *Brain*, 1893, xvi. 425.
"On Syphilitic Affections of the Spinal Cord," *Lancet*, 1894, i. 1297.
"Remarks on Cirrhosis of the Liver in Children," *Brit. M. J.*, 1894, i. 1407.
"Case of Friedreich's Disease," *Ibid.*, 1894, ii. 1294.
"Hysteria and Neurasthenia," *Brain*, 1894, xvii. 119.
"Left Hemiplegia and Motor Aphasia without Coarse Brain Lesions, *Lancet*, 1894, ii. 253.
"On the Pulsus Bisferiens of Aortic Regurgitation," *Ibid.*, p. 1529.
"Somnambulism," *Bris. Med.-Chir. J.*, 1894, xii. 81.
"Diagnosis of Cancer and Simple Dilatation of the Stomach," *Ibid.* 1895, xiii. 181.
"On Endothelioma of the Spinal Dura Mater," *Brain*, 1895, xviii. 256.
"Clinical Lecture on Apoplexy," *Clin. J.*, 1895, vii. 135.
"Case of Varicose Aneurysm of Ascending Aorta," *Lancet*, 1896, i. 155.
"Cases of Biliary Colic cured by Olive Oil," *Brit. M. J.*, 1895, ii. 76.
(With C. A. Morton) "Case Presenting Symptoms of Cerebral Tumour, in which a large area of the skull was removed for relief of intracranial pressure," *Ibid*, 1895, i. 802.
"Two Cases in which signs of the presence of Intracranial Tumour were followed by Recovery," *Ibid.*, 1897, i. 328.
"On Deep-seated Thoracic Aneurysm," *Clin. J.*, 1896, ix. 106.
"Cases of Hysterical Mutism and Motor Aphasia," *Ibid.*, p. 305.
"On the Use of Oxygen in the Treatment of Anæmia," *Bris. Med.-Chir. J.*, 1896, xiv. 232.
"Case of Acute Miliary Tuberculosis," *Ibid.*, 1897, xv. 148.
"Changes in the Spinal Cord in two cases of Pernicious Anæmia," *Brit. M. J.*, 1897, ii. 325.
(With C. A. Morton) "Operation for Abscess of the Lung due to Localised Necrosis," *Ibid.*, p. 800.
"Two Cases of Congenital Syphilitic Cirrhosis of the Liver in Infants," *Am. J. M. Sc.*, 1898, cxv. 413.

"Case of Cancer of the Pylorus presenting some unusual features,' *Lancet*, 1898, ii. 866.

"Clinical Study of the Gastric Juice," *Brit. M. J.*, 1898, ii. 1863.

"Treatment of Enteric Fever," *Bris. Med.-Chir. J.*, 1898, xvi. 15.

"On the Temperature in Cases of Apoplexy," *Ibid.*, 1899, xvii. 97.

"Epileptic Attacks preceded by Subjective Auditory and Taste Sensations," *Lancet*, 1900, i. 1119.

"Case of Ulcerative Endocarditis treated by Anti-streptococcic Serum," *Ibid.*, 1900, ii. 168.

"Case of Varicose Aneurysm of the Aorta communicating with the Pulmonary Artery," *Brit. M. J.*, 1900, ii. 1701.

(With R. G. P. Lansdown) "Case of Sarcoma of the Brain removed by Operation," *Ibid.*, 1901, i. 879.

"Two Cases of the Sporadic Form of Epidemic Cerebro-spinal Meningitis," *Bris. Med.-Chir. J.*, 1900, xviii. 128.

(With C. A. Morton) "Case of Abscess in the Left Lobe of the Cerebellum successfully Evacuated," *Ibid.*, 1901, xix. 112.

"Two Cases of Localised Necrosis of the Lung," *Ibid.*, 1902, xx. 122.

"Nystagmus," Quain's *Dictionary of Medicine*, 3rd Ed., 1902, p. 1103.

"A Case of Banti's Disease, *Bris. Med.-Chir. J.*, 1903, xxi. 14.

"Treatment of Sciatica," *Lancet*, 1903, ii. 1083.

"Case of Tuberculous Ulceration of the Intestines," *Ibid.*, 1904, ii. 147.

'On the Relation of the Argyll-Robertson Phenomenon to Syphilis," *Brit. M. J.*, 1903, ii. 1634.

"Case of Cured Hydrocephalus," *Brit. J. Child. Dis.*, 1904, i. 503.

"Spinal Cord Degenerations in Anæmia," *Brain*, 1904, xxviii. 441.

"On some Symptoms of Cerebral Tumours," *Bris. Med.-Chir. J.*, 1905. xxiii. 97.

"Presidential Address on the Relation of Medicine to the Natural Sciences" (Bath and Bristol Branch B.M.A.), *Ibid.*, p. 193.

"Two Cases of Myasthenia Gravis," *Ibid.*, p. 308.

Hysteria and Neurasthenia. London. John Lane. 1905.

"Cases Illustrating the More Unusual Complications of Pneumonia," *Bris. Med.-Chir. J.*, 1907, xxv. 89, 108.

"Treatment of Graves's Disease," *Ibid.*, p. 201.

"Lymphadenoma Treated by X-Rays," *Brit. M. J.*, 1907, ii. 1137; *Arch. Roentgen Ray*, 1908, xiii. 290.

"Clinical Lecture on Cases of Paraplegia," *Ibid.*, 1908, ii. 699.

"Case of Acute Lymphadenoma," *J. Path. and Bacteriol.*, 1908, xiii. 92.

(With H. J. Mackay) "Case of Hœmorrhagic Myelitis," *Brain*, 1908, xxxi. 514.

"The Renal Changes in a Case of Hæmorrhage into the Pons, with consequent High Blood-pressure," *Bris. Med.-Chir. J.*, 1908, xxvi. 230.

"Recent Work on Leukæmia and some Allied Affections," *Ibid.*, p. 289.

"Precautions to be observed in administration of Milk in Disease," *Ibid.*, 1909, xxvii. 57.

(With E. W. H. Groves) "Remarks on Syringomyelia occurring in Brother and Sister," *Brit. M. J.*, 1909, ii. 737.

"Recurrent Motor Paralysis in Migraine," *Ibid.*, 1910, i. 1534.

"Recurrent Paralysis," Allbutt's *System of Medicine*, 1910, viii. 604.

"Leukæmia Treated by X-Rays," *Bris. Med.-Chir. J.*, 1910, xxviii. 208.

"The Long-Fox Lecture on Cerebrospinal Syphilis," *Ibid.*, 1911, xxix. 1.

"Argyll-Robertson Sign in Cerebral and Spinal Syphilis, *Brit. M. J.*, 1911, i. 296.

"Some Features of Aortic Regurgitation in Young Subjects," *Ibid.*, p. 1364.

"Tumour of the anterior part of the Corpus Callosum extending into the Frontal Lobe," *Ibid.*, 1912, ii. 1447.

"Removal of Extra-Medullary Tumour of Cervical Cord," *Ibid.*, p. 175.

"Case of General Infection by the Influenza Bacillus," *Lancet*, 1912, i. 1465.

"Chronic Interstitial Pancreatitis of Uncertain Origin," *Bris. Med.-Chir. J.*, 1912, xxx. 97.

"Case of Acute Septicæmia due to B. Pyocyaneus," *Ibid.*, 1913, xxxi. 31; and *M. Press and Circ.*, 1913, xcv. 492.

(With C. A. Morton) "Removal of Intrathecal Tumour from Lumbar Region of Spinal Cord," *Brit. M. J.*, 1913, i. 932.

"Diseases of the Lungs associated with the presence of Friedlander's Bacillus," *Bris. Med.-Chir. J.*, 1914, xxxii. 1.

"On Toxic Polyneuritis of the Motor Type," *Ibid.*, 1915, xxxiii. 9.

(With R. G. P. Lansdown) "Intra-Medullary Tumour of the Spinal Cord," *Brit. M. J.*, 1914, i. 1009.

(With J. O. Symes) "Small Outbreak of Epidemic Cerebrospinal Meningitis," *Ibid.*, p. 1286.

"Pathological Changes in Acute Leukæmia from prolonged use of X-Rays," *Proc. Roy Soc Med.*, 1913, vii. Med. Sec., 205.

"The Bradshaw Lecture on Nervous Affections of the Sixth and Seventh Decades of Life," *Lancet*, 1915, ii. 1017, 1069.

"Gunshot Wounds of Peripheral Nerves," *Bris. Med.-Chir. J.*, 1917, xxxv. 61.

"Trench Nephritis," *Brit. M. J.*, 1917, ii. 239.

HAROLD F. MOLE.

WE regret to have to record the death at his residence, 24 College Road, Clifton, of Mr. Harold F. Mole, F.R.C.S., in his 52nd year, from heart failure consequent on asthma, from which disability he had suffered for so many years.

He was a son of F. M. Mole, Esq., of Edgbaston, Birmingham, and owing largely to his tendency to asthma was sent as a boy to school in Clifton. He subsequently studied medicine at the Bristol Medical School and Royal Infirmary, and took the diplomas of L.R.C.P., M.R.C.S. in 1890, and two years later, after a course of study at St. Bartholomew's, London, he was admitted F.R.C.S.

While a student at the Royal Infirmary he was awarded the Tibbits Memorial Prize for practical surgery, and such was his popularity that in 1891, after holding the junior resident appointments, he was made Curator of the Museum, the post having been created by the medical staff in order to retain him as a colleague. From 1895 to 1902 he was in residence, first as House Physician and then as House Surgeon and Senior

Resident Officer, where his methodical habits, combined with his clinical acumen, rendered him not only an able administrator and a most reliable resident, but also a sound surgeon and a popular tutor.

In 1902 he was elected Assistant Surgeon to the Royal Infirmary, with charge of the aural clinic. His knowledge of otology soon became very thorough, owing to the keen interest he took in the work and to the experience he gained at the Royal Ear Hospital in London, where he studied the subject for six months prior to taking up the duties of his new post. In this connection he made a set of beautiful metallic casts of the labyrinth, which will in due course be mounted in the Museum of the Bristol University.

Considering how physically weak he was, Mr. Mole displayed a wonderful amount of energy. He acted as Secretary to the Bristol Medico-Chirurgical Society from 1903 to 1907, to the *Journal* of which Society he made several contributions of great interest and much value.

In 1909 he was made full Surgeon to the Bristol Royal Infirmary and clinical teacher in Surgery to the University until 1916, when ill-health compelled him to resign these offices. The physical strain of his work in the operating theatre often taxed his powers of endurance very severely, but it was characteristic of him that he never allowed this cause to interfere with the quality of his work, He countenanced no half-measures or compromises, whatever he undertook to do he did with the very best of his ability.

A large circle of friends has been deprived of a charming personality by his death, and the medical profession has lost a highly-talented member.

In 1913 Mr. Mole married Miss H. Holmes. He leaves a widow and three children, two sons and one daughter.